Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10/28/11
Amount 390.00

#446274

I. IDENTIFICATION

Name: St. Elizabeth SNF Ft Thomas

Address: 85 North Grand Ave

City/County/Zip: Ft Thomas, Ky. 41075

Telephone number: 859-572-3530

Administrator: Wendy Bauer

Date facility operation began at current address: Jan. 1992

Date facility began operation under current owner: Jan. 1992

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	26	26
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
(Private)

Profit
(Nonprofit)

Individual
Partnership
Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

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If facility owned or leased by a corporation, complete the following:

Name of corporation St. Elizabeth Healthcare

Address of corporation One Medical Village Dr Edgewood, Ky 41017

President or Chairman John Dubus

Vice President Garren Colvin

Secretary Barbara Krohman

Treasurer Nathan Van Laningham

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Wendy Baines — Administrator — 10/26/11

Signature of authorized representative — Title — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

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